No. 98-1949

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In the

Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF *AMICUS CURIAE* AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PETITIONER LORI PEGRAM, M.D.

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INTEREST OF *AMICUS CURIAE*

With the written consent of the parties, reflected in letters on file with the Clerk of the Court, the American Medical Association ("AMA") submits this brief as *amicus curiae* in support of Petitioner Lori Pegram, M.D., pursuant to Rule 37 of this Court.[1]

The AMA, the largest association of physicians in the United States, was founded in 1847 to advance the art and science of medicine and the betterment of the health of the American people. It sponsors a vast array of educational, scientific, and public health programs. These remain its purposes today. The AMA has promulgated "The Principles of Medical Ethics," a statement of basic rules for the ethical practice of medicine. Its Council on Ethical and Judicial Affairs ("CEJA") issues opinions which apply the Principles of Medical Ethics to specific ethical issues in medicine, including fees and charges, and the relationships and interests among physicians, patients and managed care organizations ("MCOs"). These opinions are collected in an AMA publication, the *Code of Medical Ethics*.[2]

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

[2] Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics* (1998-1999 ed.).

The AMA is concerned that, if uncorrected, certain portions of the opinion in the case before the Court[3] might suggest that a physician can become a "fiduciary" under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA") when he or she (1) performs clinical services for patients who are participants in a plan subject to ERISA, or (2) receives compensation from an MCO in exchange for performing clinical services to patients who are participants in an ERISA plan.

Amicus can assist the Court in its resolution of the present case by identifying concerns raised by the decision below for the conduct of the practice of medicine, with reference to case law developments and relevant portions of the *Code of Medical Ethics*. *Amicus* will focus on the difference between duties of medical diagnosis and treatment and duties in the administration of employee benefit plans subject to ERISA. *Amicus* will suggest that clarification of the necessary elements for a claim of breach of ERISA fiduciary duty will allow lower federal courts to avoid the confusion over "fiduciary status" and "fiduciary duty" found in the decision below.

Amicus believes that a resolution of these matters by the Court will remove uncertainty over the implications of the decision below for the practice of medicine and properly restrict the application of ERISA to the operation of employee benefit plans, without intruding on the patient-physician relationship.

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[3] *Herdrich v. Pegram*, 154 F.3d 362 (7th Cir. 1998) ("*Herdrich I*"), *reh'g and reh'g en banc denied*, 170 F.3d 683 (7th Cir.) ("*Herdrich II*"), *cert. granted*, 120 S. Ct. 10 (1999).

SUMMARY OF ARGUMENT

This case involves an "employee welfare benefit plan" subject to the Employee Retirement Income Security Act of 1974 (an "ERISA plan"). Such an ERISA plan is to be distinguished from the managed care arrangement utilized by the ERISA plan to provide benefits to the ERISA plan's participants and their beneficiaries. The opinion below infers that a physician who performs clinical services for patients who are participants in an ERISA plan is a "fiduciary" to the ERISA plan, either (1) by providing diagnostic, prescriptive, therapeutic or referral services for those participants, or (2) by receiving compensation in exchange for providing those services. These inferences are contrary to ERISA and would subject physicians—who are already heavily regulated within the medical profession and by external agencies—to tremendous uncertainty as to the legal standards applicable to their practice of medicine. Therefore, the Court should clearly reject all inferences in the opinion below that physicians who are performing clinical services for ERISA plan participants and who are being paid for those services are, solely for those reasons, fiduciaries to an ERISA plan and subject to ERISA's fiduciary duty rules in the context of the patient-physician relationship.

ERISA provides an "operational" test to determine fiduciary status. One is a fiduciary "to the extent" he or she performs acts described in the statutory definition. Further, ERISA's fiduciary duties apply only to conduct as a fiduciary. The only act identified as conferring fiduciary status in the present case was "deciding disputed benefit claims," which is arguably either exercising discretionary authority or control respecting

management of an ERISA plan, or having discretionary authority or responsibility in the administration of an ERISA plan. This Court has identified specific categories of actions which constitute administration of an ERISA plan, and lower federal courts have adopted this formulation. A physician's performance of clinical services within the patient-physician relationship is qualitatively different and clearly distinguishable from the categories of actions which constitute administration or management of an ERISA plan.

Therefore, the physician's performance of clinical services for patients who happen to be ERISA plan participants is not a fiduciary act under ERISA and is consequently not subject to ERISA's fiduciary duty rules. Moreover, there is no need to apply ERISA in order to regulate the patient-physician relationship, given the extensive regulation of the practice of medicine under State and federal law, as well as under internal mechanisms established by the AMA and other organizations within the medical profession, including State and local medical societies. Further, any implication that ERISA does apply to the patient-physician relationship would raise questions of preemption of relevant State laws, and would be inconsistent with the Court's recent ERISA preemption jurisprudence.

With respect to a physician's receipt of compensation under a managed care arrangement in exchange for treating patients who are participants in an ERISA plan, analysis also focuses on the physician's role with respect to the ERISA plan. Status as an ERISA fiduciary depends on the performance of actions described in the statutory definition of the term "fiduciary." The physician, in performing clinical services within the

patient-physician relationship, is engaged in acts which are qualitatively different and distinguishable from the actions which constitute administration or management of an ERISA plan, and is therefore not a fiduciary to an ERISA plan. The fact that the physician is being paid in no way changes the non-fiduciary character of the performance of clinical services; therefore, the receipt or ability to receive compensation for performing those clinical services does not impose fiduciary status or fiduciary duty on the physician. The public interest would not be served by using ERISA to regulate the compensation of physicians in the managed care environment. Physician arrangements with MCOs are subject to extensive State and federal regulation and scrutiny; in addition, the AMA has promulgated strict ethical guidelines relating to a physician's obligations in a managed care setting. Finally, any implication that ERISA regulates the compensation of physicians in the managed care environment would be wholly inconsistent with the Court's recent jurisprudence on ERISA preemption as well as its longstanding view that the regulation of matters of health and safety is a local concern.

For these reasons, the Court should also reject all inferences that physicians who are performing clinical services for ERISA plan participants and who are being paid for those services are, solely on that basis, fiduciaries to an ERISA plan and subject to ERISA's fiduciary duty rules in the context of the patient-physician relationship.

ARGUMENT

I. When a physician performs clinical services, including making diagnostic, prescriptive, therapeutic or referral decisions, for a patient who is a participant in an ERISA plan, the physician is not acting as a fiduciary to the ERISA plan.

Determining whether a person is a fiduciary under ERISA is a straightforward exercise in statutory construction. First, one must focus on the meaning of "plan" under ERISA. The statute defines a "plan" (or "employee benefit plan") to include an "employee welfare benefit plan," an "employee pension benefit plan" or a plan that is both. 29 U.S.C. § 1002(3).

The present case does not involve an employee pension benefit plan or a hybrid welfare benefit-pension benefit plan. It involves an "employee welfare benefit plan," which is defined in the statute as follows:

> The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1) (emphasis added).

Thus, a medical benefit plan subject to ERISA: (1) is established or maintained by an employer (or employee organization, or both),[4] (2) to provide medical, surgical or hospital benefits, (3) to plan participants and beneficiaries, (4) through the purchase of insurance or otherwise. In the case before the Court, a medical benefit plan was (1) maintained by State Farm, as an employer, (2) to provide medical benefits, (3) to participants and beneficiaries, including Respondent, (4) through CarleCare HMO, "a product of Health Alliance Medical Plans, Inc." Record at 93a.

A medical benefit plan established by an employer is the true "ERISA plan," and will be referred to as such herein. It is to be distinguished from products offered by health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), provider-sponsored organizations ("PSOs") and other MCOs, such as the HMO utilized by State Farm's ERISA plan. These are not ERISA plans; rather, they are commercial products of an MCO which are sold to ERISA plans. Sometimes these MCO products use the term "plan" or "health plan" in their name, but they are not ERISA plans—they are, instead, means through which benefits of an ERISA plan can be provided.[5]

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[4] Hereinafter, the term "employer" will include, where relevant, an employee organization or combination of employer and employee organization, to refer to the entity that establishes or maintains the plan.

[5] "The words 'benefit' and 'plan' are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 (1987).

To be a "fiduciary" under ERISA, one must have one of the statutorily-specified relationships to an ERISA plan:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added).

The phrase "to the extent" is critical. One is a fiduciary to an ERISA plan only to the extent that person engages in one of the acts described in the statute, with respect to an ERISA plan.

In *Varity Corp. v. Howe*, this Court recognized the importance of the "to the extent" limitation contained in the statute:

> In relevant part, the statute says that a "person is a fiduciary with respect to a plan," and therefore subject to ERISA fiduciary duties, "to the extent" that he or she "exercises any discretionary authority or discretionary control respecting management" of the plan, or "has any discretionary authority or discretionary responsibility in the administration" of the plan.
>
> Varity was *both* an employer *and* the benefit plan's administrator, as ERISA permits. . . .

> But, obviously, not all of Varity's business activities involved plan management or administration.

516 U.S. 489, 498 (1996) (citations omitted, emphasis in original).[6] *See also Herdrich II*, 170 F.3d at 685 (Easterbrook, J., dissenting).

A corollary to the rule that one has fiduciary status only "to the extent" one's actions are described in 29 U.S.C. § 1002(21)(A), is that ERISA's fiduciary duty rules[7] are only applicable to the extent that one is acting as a fiduciary. In *Lockheed Corp. v. Spink*, this Court said: "only when fulfilling certain defined functions . . . does a person become a fiduciary under § 3(21)(A)," and "because [the] defined functions [in the definition of fiduciary] do not include plan design, an employer may decide to amend an employee benefit plan without being subject to fiduciary review." 517 U.S. 882, 890 (1996) (citing *Siskind v. Sperry Retire-*

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[6] *See also Beddall v. State Street Bank and Trust Co.*, 137 F.3d 12 (1st Cir. 1998); *Payonk v. HMW Indus. Inc.*, 883 F.2d 221, 225 (3rd Cir. 1989) ("[W]hen employers wear 'two hats' as employers and administrators, 'they assume fiduciary status only when and to the extent that they function in their capacity as plan administrators, not when they conduct business that is not regulated by ERISA.'") (quoting *Amato v. Western Union Int'l Inc.*, 773 F.2d 1402, 1416-17 (2nd Cir. 1985), *cert. dismissed*, 474 U.S. 1113 (1986)) (internal quotations omitted). *Accord LoPresti v. Terwilliger*, 126 F.3d 34, 40 (2nd Cir. 1997); *Walling v. Brady*, 125 F.3d 114, 119 (3rd Cir. 1997); *Curcio v. John Hancock Mut. Life Ins. Co.*, 33 F.3d 226, 234 n.10 (3rd Cir. 1994).

[7] 29 U.S.C. § 1104.

ment Program, Unisys, 47 F.3d 498, 505 (1995)) (internal quotations omitted) (brackets in original).[8]

Applying these rules to the fiduciary status of treating physicians, it is clear that nothing in ERISA could be read to indicate that Dr. Pegram, acting as a treating physician, was a fiduciary to State Farm's ERISA plan. Indeed, while the Seventh Circuit clearly held that Petitioners other than Dr. Pegram were fiduciaries, it is not clear whether Dr. Pegram was held to be a fiduciary to State Farm's ERISA plan:

> We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.

Herdrich I, 154 F.3d at 370 (emphasis added). Dr. Pegram was not named in Count III of Respondent's Complaint;[9] so, as a procedural matter, the decisions below should not apply to her or to other individual physicians.

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[8] *See also Hughes Aircraft Co. v. Jacobson*, 119 S. Ct. 755, 763 (1999) (holding that respondent's fiduciary duty claims were "directly foreclosed by *Spink's* holding that without exception, '[p]lan sponsors who alter the terms of a plan do not fall into the category of fiduciaries.'") (citing *Spink*); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (holding that ERISA does not authorize suits for money damages against a non-fiduciary for the non-fiduciary's participation in a breach of fiduciary duty); *Terry v. Bayer Corp.*, 145 F.3d 28, 35 (1st Cir. 1998); *Buckley Dement, Inc. v. Travelers Plan Adm'rs of Ill., Inc.*, 39 F.3d 784, 789-90 (7th Cir. 1994); *Reich v. Continental Cas. Co.*, 33 F.3d 754, 757-58 (7th Cir. 1994); *Reich v. Rowe*, 20 F.3d 25, 29-32 (1st Cir. 1994) (all holding, generally, that ERISA does not authorize suits for breach of fiduciary duty against non-fiduciaries).

[9] *Herdrich I*, 154 F.3d at 366 & 367 n.3.

However, the opinion arguably implies, in several places, that individual physicians acted as ERISA fiduciaries:

> [I]t is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

154 F.3d at 372 (emphasis added).

> [I]ncentives can rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (i.e., where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

Id. at 373 (emphasis added).

> [T]olerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of "loyalty" to his own financial interests.

Id.

> [I]t is more likely than not that an incentive existed for the Carle doctors to abuse the dual loyalties that they observed in administering the Plan. . . .

Id. at 379 (emphasis added).

Despite these implications, the opinion never says that individual physicians were "deciding disputed claims" under State Farm's ERISA plan, which is the only type of discretion the Seventh Circuit identified as

conferring fiduciary status.[10] By contrast, the physician acts described in the opinion involved treatment of patients. These clinical decisions are qualitatively very different from the decisions of ERISA fiduciaries in the administration or management of employee benefit plans. In the context of the Seventh Circuit opinion, though, physician decisions about the treatment of patients who are covered by an ERISA plan could be construed as involving ERISA plan administration. Any implication or suggestion to this effect should not be allowed to stand.

This Court has described the "administration" of employee benefit plans to include "obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9.

The Court of Appeals for the Third Circuit recently stated that:

> [A]dministrative responsibilities over the elements of the plan [include] determining eligibility for benefits, calculating those benefits, disbursing them to the participant, monitoring available funds, and keeping records.

In re U.S. Healthcare, Inc., No. 98-5222, 1999 U.S. App. LEXIS 22464, at *23 (3rd Cir. Sept. 16, 1999).[11]

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[10] 154 F.3d at 370.

[11] *See also American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 67 (D. Mass. 1997) (noting that *Fort Halifax* and *FMC Corp. v. Holliday*, 498 U.S. 52 (1990) "recognize a limited range of administrative functions (continued...)

A physician's diagnostic, prescriptive, therapeutic or referral decisions (referred to herein as "clinical services") are entirely different from the duties of plan administration identified in *Fort Halifax*. The physician is not determining the patient's eligibility under the ERISA plan; the physician is treating a patient who has come for care. The physician is not calculating or determining benefit levels; the physician is determining which of the medical procedures available is best suited to the patient's specific condition. Neither is the physician making disbursements, calculating the level of funds for benefit payments or keeping records for ERISA plan reporting. Thus, the physician, in performing clinical services for patients, is not performing any act of ERISA plan administration or management, and therefore cannot be a fiduciary to the ERISA plan:

> A surgeon exercises a great deal of discretion when deciding how (if at all) to perform an operation, but the fact that an ERISA welfare plan pays for the medical procedure does not make the physician a "fiduciary" of the patient . . . .

Herdrich II, 170 F.3d at 685 (Easterbrook, J., dissenting).

Numerous lower federal court decisions have recognized the qualitative and fundamental distinction between the practice of medicine and ERISA plan administration functions. These decisions have been made in cases which considered whether State court actions

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[11] (...continued)
which are part of operating an employee benefit plan . . . eligibility determinations, benefit calculations, disbursements, fund monitoring [and] recordkeeping.").

based on, for example, negligence or wrongful death, in the treatment of an ERISA plan participant are preempted by ERISA. (The preemption argument in such cases may be based on 29 U.S.C. § 1132(a), as interpreted by this Court in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987), on 29 U.S.C. § 1144, or on both provisions.) These cases distinguish between a claim based on the "quantity of care" an ERISA plan participant seeks and one based on the "quality of care" the participant receives. State law claims of the first type have been held to implicate ERISA plan administration (eligibility for benefits, level of benefits) and, therefore, to be preempted. The second type of State law claim, however, has been held to implicate medical decisions, or the implementation of those decisions and, therefore, has been found not to be preempted.[12]

This distinction is clearly articulated in a recent decision of the Court of Appeals for the Third Circuit:

> Thus, it is the HMO's essentially medical determination of the appropriate level of care that the Baumans claim contributed to the death of their daughter. This is not a claim that a certain benefit was requested and denied.

In re U.S. Healthcare, No. 98-5222, 1999 U.S. App. LEXIS 22464, at *25 (3rd Cir. 1999) (emphasis added).

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[12] *See, e.g., Rice v. Panchal*, 65 F.3d 637, 645 (7th Cir. 1995); *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154-55 (10th Cir. 1995); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355-57 (3rd Cir.), *cert. denied*, 516 U.S. 1009 (1995); *Phommyvong v. Muniz*, No. 3:98-CV-0070-L, 1999 U.S. Dist. LEXIS 3101, at *7-8 (N.D. Tex. March 11, 1999); *Herrera v. Lovelace Health Sys., Inc.*, 35 F. Supp.2d 1327, 1330-32 (D.N.M. 1999); *Nealy v. U.S. Healthcare HMO*, 711 N.E.2d 621, 625 (N.Y. 1999).

This distinction between the performance of clinical services and the administration of an ERISA plan resolves the physician's ERISA fiduciary status. In performing clinical services for patients who happen to be ERISA plan participants or beneficiaries, the physician is not engaged in an act described in 29 U.S.C. § 1102(21)(A). Applying *Fort Halifax*, a physician would be engaged in ERISA plan administration, which can trigger fiduciary status, only to the extent he or she determines eligibility, calculates benefits, makes disbursements, monitors funds or keeps records for an ERISA plan.[13]

Absent fiduciary activity of the kinds described in the statute, ERISA's fiduciary duty rules are inapplicable. Failure to heed this principle led to the confusion in the opinion below. That opinion identifies a fiduciary act—"deciding disputed claims." *Herdrich I*, 154 F.3d at 370. However, the physician conduct which the Seventh Circuit described did not involve deciding disputed claims.

In order to avoid such confusion, this Court should reiterate that, to properly state a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that: (1) defendants have engaged in conduct described in 29 U.S.C. § 1002(21)(A) with respect to a plan covered by ERISA; (2) in the course of that conduct they breached their fiduciary duties; and (3) a cognizable loss resulted from that breach.

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[13] An individual physician could certainly become a fiduciary under an ERISA plan. He or she could, for example, be a member of the plan administration committee at the hospital or clinic where he or she is employed and, as a member, make decisions regarding eligibility of an employee or the level of benefits to which a participant is entitled. There is no allegation that Dr. Pegram played such a role in this case.

Under this formulation, which is consistent with the statute and prior decisions of this Court, the allegation that a person performed some fiduciary function for an ERISA plan will not imply that other, non-fiduciary conduct is subject to ERISA's fiduciary duty. Thus, a physician making a diagnostic decision concerning a patient covered by an ERISA plan (such as Dr. Pegram's decision that Respondent's condition did not warrant an immediate ultrasound) will not, by making such a diagnosis, be converted into an ERISA fiduciary:

> Lori Pegram, a physician employed by Carle, scheduled Herdrich for an ultrasound examination in Urbana on one day rather than in Bloomington on another; that does not sound like an exercise of discretion "in the administration of [the] plan."

Herdrich II, 170 F.3d at 685 (Easterbrook, J., dissenting).

To convert a physician performing clinical services into an ERISA fiduciary makes his or her clinical conduct subject to ERISA rules and standards, but ERISA was never intended to regulate the practice of medicine:

> The focus of [ERISA] thus is on the administrative integrity of benefit plans . . . .

Fort Halifax, 482 U.S. at 15.

> When Congress enacted ERISA it was concerned in large part with the various mechanisms and institutions involved in the funding and payment of plan benefits.

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 357 (3rd Cir.), *cert. denied*, 516 U.S. 1009 (1995).

This is not to say that physicians should—or would—be unregulated in making medical decisions if those decisions are not regulated by ERISA. For example, professional liability claims may be brought under State law whenever a patient believes the physician has violated any duties in the patient-physician relationship.[14] Respondent, in fact, prevailed in such a claim:

> Herdrich has recovered $35,000 in damages for medical malpractice. She wants more. . . .

Herdrich II, 170 F.3d 683 (7th Cir. 1999) (Easterbrook, J., dissenting).

Professional liability is only one of many forms of regulation of physician conduct. Indeed, *amicus* believes that, between the external regulation of the practice of medicine under State and federal law, and the medical profession's own self-policing, no other profession is as extensively regulated as the medical profession.

The laws of each State define what constitutes the practice of medicine. They also define the criteria for licensure of physicians, establish a process for admitting physicians to practice, and set forth procedures for determining when they may no longer practice. Physicians are subject to disciplinary action (including fines, censure, reprimand, and loss of license) under the laws of every State if they fail to conform their services to national and local standards of care. *See, e.g.*, Illinois Medical Practice Act of 1987, 225 Ill. Comp. Stat. 60/1 *et seq.* (West 1999).

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[14] *See generally* T. Metzloff & F. Sloan, *Medical Malpractice: External Influences and Controls*, 60 Law & Contemp. Probs. 1 & 2 (1997). *See also* Joel L. Michaels, American Medical Association, *The Regulation of Managed Care Organizations: A Legal Perspective* (1994).

Moreover, physicians who are disciplined by State medical boards or found liable in tort cases are, more and more frequently, listed in State databases and on agency websites for review by the appropriate regulatory body. Physician licensing and disciplinary codes, regulations, and board of medicine opinions in most States are complex and precise, covering physician conduct in every area of practice. Many States' disciplinary codes permit or require State medical licensure boards to exact penalties where physicians fail to adhere to broad standards regarding the quantity, type, method, or setting of diagnostic or treatment services or supplies, referrals, or medical management services. *See, e.g.*, Illinois Medical Practice Act of 1987, 225 Ill. Comp. Stat. 60/1 *et seq.* (West 1999); Florida Medical Practice Act, Fla. Stat. Ann. ch. 458.331 (West Supp. 1999); New York Medical Practice Act, N.Y. Educ. Law § 6509 (McKinney 1999).

Physicians are also subject to multiple laws and guidelines that mandate conformance with rigorous quality and performance measures. For example, the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* ("HCQIA") and its implementing regulations impose a system of comprehensive scrutiny of physician quality. *See* 45 C.F.R. Part 60, *National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners* ("NPDB").

Under HCQIA, each State medical board must report to the NPDB specific information whenever it takes any action against a physician for reasons relating to a physician's professional competence, qualifications, conduct, or performance, which revokes or suspends licensure, censures or reprimands a physician or places him or

her on probation. HCQIA requires or permits reporting of adverse clinical privileges actions taken by health care entities and adverse professional membership actions taken by professional societies. 45 C.F.R. § 60.9 (1999). This requirement covers all settlements and judgments concerning professional liability (whether reported by professional liability insurers or hospital co-defendants) and corrective actions or discharges from hospital medical staffs. It further requires hospitals and permits other entities to query the NPDB in enumerated circumstances, such as when a physician applies for membership on a hospital's medical staff; when an MCO or other health care entity wishes to hire or contract with a physician, or comply with its own accreditation criteria; and for professional review activities. 45 C.F.R. § 60.10 (1999); 45 C.F.R. § 60.11 (1999).

Physicians are subject to extensive direct and indirect scrutiny and certification standards by private third-party accrediting bodies. For example, the National Committee for Quality Assurance ("NCQA") accredits physician organizations, requiring them to maintain high standards and rigorous quality measures in the following areas: administrative policies and procedures, MCO contracting capabilities, "Quality Management and Improvement," "Utilization Management," "Members' Rights and Responsibilities," "Preventive Health Services," "Credentialing and Recredentialing," and "Medical Records." National Committee for Quality Assurance, *Standards for the Accreditation of Managed Care Organizations* (1999). Within these categories of standards, individual criteria require compliance with specific dictates, such as making services accessible to patients, ensuring member satisfaction, providing chronic disease management and prevention services,

and conducting research to ensure efficacy of treatments. Increasingly, physician organizations will be unable to obtain MCO contracts without compliance with such third-party quality and care delivery standards. Moreover, even if physician organizations do not seek voluntary third-party accreditation from organizations such as NCQA, most MCOs do seek such accreditation, which typically requires the MCO to ensure compliance with these criteria in its contracts with physicians. National Committee for Quality Assurance, *Surveyor for the Certification of Physician Organizations* (1999).

In addition to these external restrictions on physician behavior, organized medicine imposes its own scheme of regulation of professional conduct. Physicians police themselves rigorously through professional certification and peer review. Physician societies, associations, hospital medical staffs, institutional review boards, specialty boards, and hospital committees all strictly regulate individual physician qualifications and service quality. Highly-developed peer review activities occur in hospitals and medical centers in which physicians undertake to evaluate each other. Such peer review has been granted credence in Medicare, Medicaid and other governmental programs for decades. 42 C.F.R. § 462.1 *et seq*. The AMA's Council on Ethical and Judicial Affairs may censure, suspend, or expel AMA members for a violation of the Principles of Medical Ethics or for other unethical or illegal conduct. AMA Bylaws, § 1.60. Other medical societies have similar disciplinary powers. Such disciplinary actions are reported to the NPDB, pursuant to 42 U.S.C. § 11133(a)(1)(C).

The majority of acute care institutional health care organizations implement organizational and governance

standards through voluntary accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), a quality oversight body for healthcare organizations and managed care entities. JCAHO accreditation provides organizational and quality standards for medical staffs.[15] Additionally, JCAHO performs routine inspections of accredited medical staffs to confirm adherence to its standards. Compliance with JCAHO requirements generally assures compliance with applicable federal and state requirements concerning the governance of medical staffs. Compliance with JCAHO standards also assures compliance with Medicare certification standards. Moreover, compliance with JCAHO standards provides another layer of external review and oversight over physicians' conduct.

Finally, *amicus* notes that the failure to distinguish physicians' clinical services from ERISA plan administration may create an inference that ERISA would preempt application of State regulation of the practice of medicine. The argument would be that, if physicians can be held to be acting as ERISA fiduciaries in performing clinical services to ERISA plan participants, ERISA provides a remedy for breaches of fiduciary duty,[16] and that remedy preempts a State law cause of action arising out of the same conduct. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1987) and *Metropolitan Life Insurance Co. v. Taylor,* 481 U.S. 58, 63-67 (1987).

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[15] JCAHO, *Accreditation Manual for Hospitals* (1998); *see also* JCAHO, *The Medical Staff Handbook: A Guide to Joint Commission Standards* (1999).

[16] *See* 29 U.S.C. §§ 1109, 1132(1), (2) and (3).

Such a result would be contrary to the statute and to prior decisions of this Court:

> [N]othing in the language of [ERISA] or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . .

N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 661 (1995) (citations omitted).

> We find nothing in the legislative history suggesting that [ERISA] § 502 was intended as a part of a federal scheme to control the quality of the benefits received by plan participants.

Dukes v. U.S. Healthcare, Inc., 57 F.3d at 357.

> We recognize that the States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions.

Goldfarb v. Virginia State Bar, 421 U.S. 773, 792 (1975). *See also Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 611 (1935).

Nonetheless, such preemption claims could be made, if any implication were to remain that performing clinical services for patients who are ERISA plan participants is a matter of ERISA plan administration, subject to ERISA's fiduciary duty rules. Such an implication should not exist—nothing in the language or legislative history of ERISA suggests that it was ever intended to create a code for the practice of medicine.

For these reasons, *amicus* urges the Court to clearly reiterate the necessary elements of a claim for breach of fiduciary duty under ERISA and, in doing so, eliminate any implication that a physician making diagnostic and treatment decisions is acting as an ERISA fiduciary.

II. A physician's compensation agreement with a managed care organization, under which he or she is paid for performing clinical services for patients who are ERISA plan participants, does not cause the physician to become a fiduciary to the ERISA plan.

An employer may provide the benefits available under an ERISA plan "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Many employers provide the benefits available under an ERISA plan through a contract with an MCO. This is what State Farm did in the case before the Court.

An MCO puts together and markets managed care products (whose features typically include covered services, designated providers and compensation of providers) which can be utilized by ERISA plans or non-ERISA plans to provide benefits. These MCO products are not the ERISA plan. They are products purchased by ERISA plans. An ERISA plan can switch from one MCO product to another, or it can choose to provide benefits in a different way, such as through a group health insurance contract. The ERISA plan is still the ERISA plan, as distinguished from any product it uses to provide benefits.

This distinction was articulated in a 1998 decision of the Court of Appeals for the Ninth Circuit in a case

which considered whether ERISA preempted a Washington State statute which regulated the structure of MCO provider networks:

> [T]he Act . . . does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy. . . . The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a regulation of health insurance automatically to "relate to" an employee benefit plan—just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans. After *Travelers*, ERISA plans no longer have a Midas touch that allows them to deregulate every product they choose to buy as part of their employee benefit plan. . . .
>
> Accordingly, the mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it "relates to" an ERISA plan.

Washington Physicians Service Association v. Gregoire, 147 F.3d 1039, 1044-45 (9th Cir. 1998), *cert. denied*, 119 S. Ct. 1033 (1999).[17]

When an ERISA plan uses an MCO's product to provide benefits, the employer may pay the MCO, or the MCO may be paid out of ERISA plan assets. The MCO, in turn, compensates its providers, including physicians.

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[17] *See also Herdrich II*, 170 F.3d at 686 (Easterbrook, J., dissenting).

As discussed at pages 6-23 of this brief, when a physician performs clinical services for a patient, the fact that the patient is a participant in an ERISA plan does not turn those clinical services into plan administration.

As discussed at page 8 of this brief, there is no fiduciary duty where there is no fiduciary act. Since the physician, performing clinical services, is not acting as a fiduciary to an ERISA plan, he or she cannot breach any ERISA fiduciary duty by being paid for performing those non-fiduciary services. The ERISA plan pays the agreed-upon price for the MCO product and, for that consideration, the MCO's physicians provide clinical services to participants in the ERISA plan. The physicians are paid for performing those clinical services. If a patient/participant is dissatisfied with the clinical services provided, there are ample means to seek redress.[18] If the ERISA plan (or its employer sponsor) is dissatisfied with the services the MCO provides, it can switch to another MCO or some other means of providing benefits.[19] Within this framework, nothing supports an inference that paying a physician for performing clinical services to ERISA plan participants makes the physician an ERISA fiduciary.[20] The opinion below, to the extent that it contairs any implication to the contrary, must be rejected.

A physician's potential conflict of interest under some MCO compensation arrangements should not and would

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[18] *See* pages 16-21, *supra*.

[19] *Herdrich I*, 154 F.3d at 382 (Flaum, J., dissenting).

[20] *Amicus* does not address whether this analysis would be the same where a physician is also an owner of an MCO.

not be unregulated as a result of the statutory limitations of ERISA. As described in the following paragraphs, the AMA has provided detailed guidance on a physician's ethical obligations regarding MCO compensation arrangements. This guidance is widely accepted, both under state law and in the medical profession's own self-regulation procedures.

Since 1986, CEJA has issued a number of opinions relating to ethical concerns that have been raised in connection with MCO arrangements.[21] These opinions recognize that the fundamental ethical obligation of a physician is, at all times, to deal honestly with patients and not to place the physician's own financial interests above the welfare of his or her patients.[22] The relationship of trust between a physician and a patient for whom he or she is providing clinical services creates an affirmative ethical obligation for the physician to disclose any prohibition on referral sources for diagnostic or therapeutic services the physician believes the patient's condition warrants, so that a patient can decide whether to incur out-of-pocket expenses or accept the referral sources covered by the MCO arrangement.[23] The physician has an ethical obligation to assure the disclosure of medically appropriate treatment alternatives, regardless of cost. Neither the promise of financial reward nor the threat of financial penalties alters

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[21] *See generally* CEJA Ops. 8.13, 8.132, 8.135 and 8.137, *Code of Medical Ethics* at 143-49; Council on Ethical and Judicial Affairs, American Medical Association, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995).

[22] CEJA Op. 8.13(1), *Code of Medical Ethics* at 143.

[23] CEJA Op. 8.132, *Code of Medical Ethics* at 147.

these ethical disclosure obligations, where failure to disclose would deny a patient access to appropriate medical services.[24]

When physicians are employed by or reimbursed by managed care plans that offer financial incentives to limit care, potential conflicts are created between the physicians' personal financial interests and the needs of their patients. The AMA's ethical guidelines warn physicians of financial incentives that extend beyond the permissible goal of promoting cost-effective delivery of health care and can result in the withholding of medically necessary care.[25] Physicians have an ethical obligation to assure disclosure of any financial inducements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or that may tend to limit patients' overall access to care.[26] The ethical guideline specifies that physicians can satisfy this ethical obligation by assuring that the "managed care plan" provides adeqate disclosure to patients enrolled in the "plan."[27] The ethical guideline, then, acknowledges the reality that physicians are often not in the best position to provide information regarding MCO financial arrangements. A typical physician sees patients covered by numerous MCO arrangements, all with different, and usually complex, rules. Such disclo-

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[24] *Id.*

[25] CEJA Op. 8.13(3), *Code of Medical Ethics* at 144.

[26] *Id. See Neade v. Portes*, 710 N.E.2d 418, 427 (Ill. App. 1999), *appeal docketed*, No. 87445 (Ill. Oct. 6, 1999) (citing CEJA Op. 8.132).

[27] *Id.*

sures are most effectively provided by the MCO, either directly or through the ERISA plan.[28]

If a particular procedure is not covered by an MCO product or if the MCO declines to authorize a procedure recommended by the physician, the physician has an ethical obligation to advocate for care he or she believes will materially benefit the patient, regardless of such restrictions.[29] These obligations are fundamental elements of the patient-physician relationship, regardless of whether the patient is an ERISA plan participant.

Every State requires that physicians maintain accepted standards of professional behavior. Such standards are frequently embodied in State licensing statutes and regulations as well as court decisions. The AMA's ethical guidelines are commonly recognized as an element of those professional standards. *See Code of Medical Ethics* (1998-1999 ed.). Ohio and Kentucky have explicitly required, by statute, that physicians practicing in those States conform to the AMA's Code of Medical Ethics. Ohio Rev. Code Ann. § 4731.22 (B)(18) (Baldwin 1999); Ky. Rev. Stat. Ann. § 311.597(4) (Baldwin 1998). Similarly, Tennessee has adopted the Code of Medical Ethics by regulatory policy. *Swafford v. Harris*, 967 S.W.2d 319 (Tenn. 1998). Even in those States that have not specifically adopted the AMA's ethical policies, its Code of Medical Ethics is persuasive authority that guides the judgments of individual physicians, courts, and regulatory agencies.

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[28] CEJA Op. 8.132, *Code of Medical Ethics* at 147.

[29] CEJA Op. 8.13(2)(b), *Code of Medical Ethics* at 143.

Therefore, there is no public interest in stretching ERISA beyond its statutory limits in order to regulate how a physician is paid for performing clinical services for patients. Moreover, the implication in the Seventh Circuit opinion that ERISA applies to MCO compensation of physicians for performing clinical services might support arguments that existing regulation under "State law," as defined in 29 U.S.C. § 1144(c)(1), would be preempted by ERISA, even though such claims could not withstand scrutiny under this Court's recent preemption jurisprudence. See pages 21-22 of this brief. Indeed, this Court has long recognized that the regulation of the practice of medicine is essentially a State concern:

> [T]he regulation of health and safety matters is primarily, and historically, a matter of local concern.

Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707, 719 (1985) (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218 (1947)).

For these reasons, *amicus* urges the Court to specifically reject any implication in the decision below that a physician's compensation arrangement with an MCO, under which he or she is paid for performing clinical services with respect to patients who are ERISA plan participants, causes the physician to become a fiduciary to the ERISA plan.

CONCLUSION

For the foregoing reasons, *amicus* urges the Court, first, to clearly reiterate the necessary elements of a claim for breach of fiduciary duty under ERISA and, in

doing so, eliminate any implication in the decision below that a physician making diagnostic and treatment decisions is engaged in the administration of an ERISA plan. *Amicus* also urges the Court to specifically reject any implication in the decision below that a physician's compensation arrangement with an MCO, under which he or she is paid for performing clinical services with respect to patients who are ERISA plan participants, could cause the physician to become a fiduciary to the ERISA plan.

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